Spa Client Medical History

Personal Information

Full Name

Date of Birth

Gender

Room Number

Email Address

Phone Number

Medical Information

Are you currently under medical treatment?

Yes No

If yes, please specify

Do you have any allergies?

Yes No

If yes, please specify

Conditions (Check all that apply)

Heart Condition Diabetes Pregnant High Blood Pressure Low Blood Pressure Skin Condition Epilepsy Asthma Recent Injury None

Other medical conditions or concerns

Current Medications

Please list any medications you are currently taking

Consent

I confirm that the above information is accurate and complete to the best of my knowledge.

Signature

Date